Stony Brook
Orthopaedic Associates

IVAN ZAPOLSKY, M.D.

SPINE AND SCOLIOSIS CENTER

TODAY'S DATE: _______________
PATIENT NAME: ________________________________ DOB: _____________ Gender____
PRIMARY LANGUAGE: ENGLISH____ SPANISH____ OTHER_______________
CAN YOU READ ENGLISH YES ___ NO ___ DO YOU UNDERSTAND ENGLISH YES ___ NO ____

DID YOU SUFFER AN INJURY? YES____ NO____ DATE__/__/___ IS IT WORK RELATED? YES___ NO ___
DESCRIBE THE INJURY:
____
WHEN DID THE PAIN/SYMPTOMS BEGIN? DATE__/__/___
HOW DID THE PAIN START? ____
WHERE IS THE PAIN LOCATED? NECK___ MID-BACK___ LOW-BACK___ ARM___ LEG___
DESCRIBE ____
DOES THE PAIN AWAKEN YOU FROM SLEEP? YES ___ NO ___
ARE YOUR SYMPTOMS: IMPROVING___ WORSENING___ STAYING THE SAME OVER TIME ___
WHAT AGGRAVATES YOUR PAIN? ____
WHAT HELPS YOUR PAIN? ____

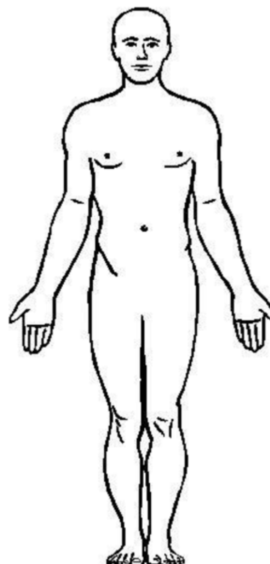
HAVE YOU HAD TREATMENT FOR YOUR CONDITION? YES___ NO ___
MEDICATIONS____ PHYSICAL THERAPY___ CHIROPRACTOR___ ACUPUNCTURE ___
TRIGGER POINT INJECTIONS____ EPIDURAL STEROID ___ SURGERY___ OTHER___________________

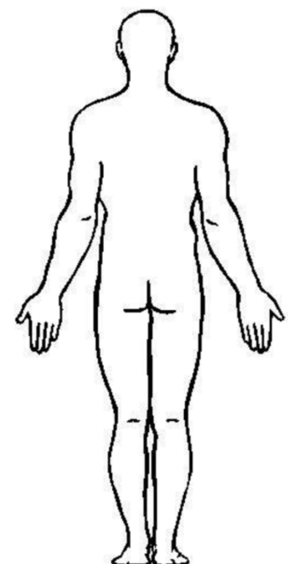
PLEASE RATE PAIN ACCORDING TO THE SCALE BELOW

0	1	2	3	4	5	6	7	8	9	10
NO PAIN		MILD		DISCOMFORT		DISTRESSING		HORRIBLE		EXCRUCIATING

WHERE ARE YOUR SYMPTOMS?
PLEASE USE THE SYMBOLS ON THE LEFT TO MARK THE LOCATION AS ACCURATELY AS POSSIBLE ON THE BODY DRAWING:

PAIN	X X X X
BURNING TINGLING	∿∿∿∿
NUMBNESS	O O O O





MEDICAL HISTORY:

DIABETES? YES____ NO ____ HEART ATTACK OR STROKE? YES____ NO ____
BLOOD CLOT? YES____ NO ____ KIDNEY DISEASE? YES____ NO ____

PLEASE DETAIL ADDITIONAL PAST MEDICAL HISTORY: ____

PLEASE DETAIL PAST SURGICAL HISTORY: ____

PLEASE LIST ALL CURRENT MEDICATIONS: (PLEASE CONTINUE ON BACK OF THIS PAPER IF YOU NEED MORE ROOM)

DRUG	DOSE	FREQUENCY

PLEASE LIST ANY ALLERGIES: ____

WHAT IS YOUR OCCUPATION? ____
TYPE OF WORK: HEAVY LABOR ________ LIGHT LABOR______ SEDENTARY/DESK ________
ARE YOU CURRENTLY EMPLOYED? YES____ NO ____
STATUS: FULL TIME____ PART TIME____ DECREASED CAPACITY____ DISABLED____ RETIRED____
IF NOT WORKING, WHEN DID YOU STOP? ___/___/___

DO YOU SMOKE? YES____ NO____ CIGARETTES _____ CIGARS_______ PIPE ______ OTHER ________
DO YOU DRINK? YES____ NO____ IF YES, HOW OFTEN _________ HOW MANY ________

DO YOU HAVE ANY SIGNIFICANT FAMILY MEDICAL HISTORY? FOR EXAMPLE, BLOOD CLOTS, CANCER, KIDNEY DISEASE, HEART DISEASE

DESCRIBE: ____

REVIEW OF SYSTEMS

(CHECK ALL THAT APPLY)

GENERAL

- ☐ CHEST PAIN
- ☐ FAINTING/DIZZINESS
- ☐ SEIZURES
- ☐ HEADACHES
- ☐ SHORTNESS OF BREATH
- ☐ COUGH
- ☐ LEG/FOOT SWELLING
- ☐ SKIN RASH/ULCERS
- ☐ FEVERS/CHILLS
- ☐ SNORING
- ☐ ABNORMAL BLEEDING
- ☐ UNEXPLAINED WEIGHT LOSS

NEUROLOGIC

- ☐ NUMBNESS OF HANDS
- ☐ NUMBNESS OF FEET
- ☐ BALANCE PROBLEMS
- ☐ HAND COORDINATION PROBLEMS
- ☐ MUSCLE WEAKNESS

______________________________ ______________________
PATIENT/GUARDIAN SIGNATURE DATE